

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9067

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10138

1  
FOR STATE  
HEALTH DEPT.

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1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>			b. COUNTY <b>Dorchester Co.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland.</b>			c. LENGTH OF STAY IN 1b <b>Life</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Yacht Basin</b>			d. STREET ADDRESS <b>Edlon Park</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Norman Eldridge Adams Jr.</b>			4. DATE OF DEATH Month <b>8</b> Day <b>18</b> Year <b>1961</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 4 1953</b>		9. AGE (In years last birthday) <b>8</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>18</b>		IF UNDER 24 HRS. Hours <b>18</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (State or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Eldridge Adams</b>			14. MOTHER'S MAIDEN NAME <b>Margolyn Peters</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Eldridge Adams Edlon Park Cambridge, Md.</b>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidental Drowning</b> <b>929.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Fell into Yacht Basin while playing on pier.</b>					
20c. TIME OF INJURY Month, Day, Year <b>Ab 7 p.m. 8/18/61</b>			2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Camb. Yacht Basin Cambridge, Dor. Md.</b>			2Df. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John Mace Jr.</b>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>8/22/61</b>		
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>			Address (Street, city, town, or county) <b>Cambridge, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8/20/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Cambridge, Maryland.</b>	
23. FUNERAL DIRECTOR <b>Le Compte Funeral Service, Cambridge, Md.</b>			ADDRESS			24a. RECEIVED BY REGISTRAR <b>SEP 11 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09059

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dor.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>				c. LENGTH OF STAY IN 1b <b>3 1/2 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>28 Poplar St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>THOMAS</b> Last <b>ANDREWS</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>28</b> Year <b>1961</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/14/87</b>	
9. AGE (In years lost birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>William E. Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Mary Frances Todd</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome due to cerebral arteriosclerosis, with psychosis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 3</b> 1958, to <b>Aug 28</b> 1961, that (I) (we) last saw the deceased alive on <b>Aug 28</b> 1961, and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas J. Dredge</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8-28-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>				22d. ADDRESS <b>E.S.S Hospital, Cambridge, Md.</b>			
23a. BURIAL OR CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>August 30</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas Jr.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9069

## CERTIFICATE OF DEATH

Item 14 Film G293 8/17/61 mh

09060

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>115 Maryland Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Lois Grace Ball</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>August 12 1961</b> Day Month Year			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>September 23, 1913</b> Yrs. Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Hollands Island</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>John Harrison</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>217-28-3961</b>			
<b>17. INFORMANT</b> <b>Herbert L. Ball Sr.</b>				<b>Address</b> <b>115 Maryland Ave.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Infarction - Anterior Fibular</b> (b) <b>Endocarditis</b> (c) <b>Rheumatic CVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>415X</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Thoracoplasty Left &amp; Right Lung Lower Lobe</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>9-14 1961</b> Hour a.m. p.m. <b>19</b>							
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>3 Church St. Cambridge, Md.</b>							
<b>20f. (City or town)</b> <b>Cambridge</b> (County) <b>Dorchester</b> (State) <b>Md.</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>9-14 1961</b> , to <b>9-12 1961</b> , that (I) (we) last saw the deceased alive on <b>9-11 1961</b> , and that death occurred at <b>5:45 A.M.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>W. N. Baumann, M.D.</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <b>9-12-61</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>W. N. Baumann, M.D.</b>				<b>22d. ADDRESS</b> <b>3 Church St. Cambridge, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Aug. 14, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Dorchester Mem. Park</b>		<b>23d. LOCATION (City, town or county)</b> <b>Cambridge, Maryland</b> (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Kenneth R. Thonoff</b>				<b>25a. REC'D BY REGISTRAR</b> <b>Aug 15 1961</b>			
<b>ADDRESS</b> <b>Cambridge, Maryland</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Conrad S. Finner</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

(M)

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Benches

Cambridge

Male

Cambridge

Cambridge, Massachusetts

115, Washington Ave.

John

Grace

Ball

August 15

21

Female White

Homes

Holliston, Mass.

John Harrison

1900

no

21 - 22-1901 Boston, Mass.

W. H. Harrison, N. H.

Aug. 10, 1901 Boston, Mass.

Cambridge, Mass.



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, the delay should be noted in the space provided. The certificate should be executed by the medical examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

VS. A15ME  
5M 7/59

3  
MAY 1961  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9070 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09061

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>219 Muir St</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>219 Muir St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James</b>		First <b>A.</b> Middle <b>Banks</b> Last		4. DATE OF DEATH <b>August 15 1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/24/1886</b>		9. AGE (In years last birthday) <b>74</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster House</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Sandy Cornish</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Banks</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-8491</b>		17. INFORMANT <b>Rosalie Cooper</b> Address <b>Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. <b>John Mace Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/16/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/20/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Old Field Cemetery</b>			
23. FUNERAL DIRECTOR <b>Herbert St. Clair</b>		ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 22 61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>			

MEDICAL CERTIFICATION

100-100000  
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100-100000

James

Watts

Laborer

Sandy Cornish

Banker

12/23/1988

Green House

Design Bank

100-100000

Coramery occasion

*James Watts*

Old field Coramery

100-100000

100-100000

Harvard 20, 1988



9071

## CERTIFICATE OF DEATH

Reg. Dist. No.

09062

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>12 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge, Md. Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
				f. STREET ADDRESS <b>3 Robbins St.</b>			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Collins Banks</b>				4. DATE OF DEATH Month Day Year <b>Aug. 8 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 6, 1904</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fertilizer MFG</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>James Mc. Daniel</b>				14. MOTHER'S MAIDEN NAME <b>Nannie Banks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>220-01-0618</b>		17. INFORMANT Address <b>Martha Banks Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIA BETES M. HYPERTENSION</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7 AUG. 1961</b> to <b>8 AUG. 1961</b> , that I last saw the deceased alive on <b>7 AUG. 1961</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>105 CHURCH ST CAMBRIDGE MD.</b> DATE SIGNED <b>11 AUG 61</b>							
ACTUAL SIGNATURE <b>W. E. Guinby Jr.</b>		PHYSICIAN'S NAME (Type) <b>W. E. GUINBY JR CAMBRIDGE MD.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/14/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trappe Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Trappe, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert M. St. Clair Jr.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

B120-1-0-0835

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9072

## CERTIFICATE OF DEATH

Reg. Dist. No.

119063

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>				c. LENGTH OF STAY IN 1b <b>32 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Preston</b> Last <b>Boring</b>				4. DATE OF DEATH Month <b>Aug</b> Day <b>30</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22 1874</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>30</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sta. Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Boring</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Fleagle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-9957</b>		17. INFORMANT <b>Hospital Records Cambridge Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNK</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNK</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 1. 19 p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cambridge</b>				20g. (County) <b>Dorchester</b>		20h. (State) <b>Md</b>	
21. I certify that I attended the deceased from <b>July 28</b> , 1961, to <b>Aug 30</b> , 1961, that I last saw the deceased alive on <b>Aug 29</b> , 1961, and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>E.S.S. Hospital, Cambridge, Md.</b> DATE SIGNED <b>8-30-61</b>							
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Aug 30 1961</b>		<b>Greenmount Cemetery</b>		<b>Greenmount Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hamilton Harrison St. Michael</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 5 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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9073  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09064

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>17mo-11 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>RFD #2 23x-2</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gordon Henry Bowen</b>		4. DATE OF DEATH Month Day Year <b>Aug 10 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18 1912</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own bar</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland, Snow Hill</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Isaac Bowen</b>		14. MOTHER'S MARDEN NAME <b>Pearl Hales</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>World War Army</b>		16. SOCIAL SECURITY NO. <b>38-24-2769</b>	
17. INFORMANT <b>Hospital Records Cambridge Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>UNK</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1 1961</b> to <b>Aug 10 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 9 1961</b> , and that death occurred at <b>6:15 M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas J Dredge</b>		22b. DATE SIGNED <b>8-10-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>		22d. ADDRESS <b>E.S.S.Hospital, Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Aug 12/61</b>		23b. DATE THEREOF <b>Aug 12/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bates Methodist Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Snow Hill Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wayne Dennis</b>		25a. REC'D BY REGISTRAR <b>Aug 14 '61</b>	
ADDRESS <b>Snow Hill, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

1073

1902-11-27

John Brown  
C. W. West

1902-11-27

1902-11-27

John Brown  
C. W. West



9074  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 09065

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale - Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale - Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eldorado</b>				d. STREET ADDRESS <b>Eldorado</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Wainwright</b> Last <b>Brinsfield</b>				4. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 10, 1900</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>W. George Wainwright</b>				14. MOTHER'S MAIDEN NAME <b>Jennie D. Brinsfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-9650</b>		17. INFORMANT <b>Elwood H. Brinsfield, Rhodesdale, Md., R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic sarcoma of the Breast</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Seaford, Del.</b>	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 10 1961</b> to <b>Aug 12 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 10 1961</b> , and that death occurred at <b>8:28 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>R. Kingsbury</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Seaford, Del.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 15, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eldorado Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Eldorado, Dorchester Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Framptom and Son, Federalsburg, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

3058

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9075

09066

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>25 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>				e. STREET ADDRESS <b>134 East Appleby Ave.,</b>			
3. NAME OF DECEASED (Type or print) First <b>Sina</b> Middle <b>Gertrude</b> Last <b>Burton</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 23, 1889</b>	9. AGE (In years last birthday) <b>71 yrs.</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <b>Applegarth's, Dor. Co.,</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>James E. Ruark</b>				14. MOTHER'S MAIDEN NAME <b>Julia Lewis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>R. Julian Burton, E. Appleby Ave., Cambridge, Md.</b>			
17. INFORMANT <b>R. Julian Burton, E. Appleby Ave., Cambridge, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LYMPHO SARCOMA, GENERALIZED</b> <b>200.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 1/2 yrs</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 28, 1958</b> to <b>Aug 25, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 24, 1961</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Alfred R. Maryanov</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALFRED R. MARYANOV</b>				22d. ADDRESS <b>136 RACE ST, CAMBRIDGE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>August 27, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas</b>				ADDRESS <b>Cambridge, Md.</b>		25a. RECEIVED BY REGISTRAR <b>AUG 29 1961</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Haines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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Examiner

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
09067

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b> d. STREET ADDRESS <b>609 East</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Christopher Collins</b> First Middle Last 4. DATE OF DEATH <b>Aug 6 1961</b> Month Day Year		5. SEX <b>M</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Aug 8 1889</b> 9. AGE (In years lost birthday) <b>72</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>ENGINEER ON R.R.</b> 11. BIRTHPLACE (State or foreign country) <b>USA</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Josisha Collins</b> 14. MOTHER'S MAIDEN NAME <b>MARY Elizabeth West</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> 16. SOCIAL SECURITY NO. <b>716-01-6970</b> 17. INFORMANT <b>Hospital Records Cambridge Md</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Arteriosclerosis</b> <b>450</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNK</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 4 1961</b> to <b>Aug 6 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 6 1961</b> , and that death occurred at <b>2:15 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas J. Dredge</b> 22c. PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>		22b. DATE SIGNED <b>Aug 6 61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS <b>E.S.S. Hospital, Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>8-9-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>St. Olive</b> 23d. LOCATION (City, town, or county) (State) <b>Delmar Del</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Hanna</b> 25b. REGISTRAR'S SIGNATURE DATE <b>AUG 8 '61</b>	

100-100000

MAINTENANCE OF RECORDS  
UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

100-100000

(M)



(P)





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 9/60

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>9077</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>09068</div> </div> </div> <div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Dorchester</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>Virginia</div> </div> </div> <div> <div> <div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Williamsburg</div> </div> <div> <div>c. LENGTH OF STAY IN 1b</div> <div>1 yr 4mos</div> </div> </div> <div> <div> <div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> </div> <div> <div>d. STREET ADDRESS</div> <div>Painter</div> </div> </div> </div> <div> <div> <div>3. NAME OF DECEASED (Type or print)</div> <div>FLOYD COLLINS</div> </div> <div> <div>4. DATE OF DEATH</div> <div>August 7, 1961</div> </div> </div> <div> <div> <div>5. SEX</div> <div>Male</div> </div> <div> <div>6. COLOR OR RACE</div> <div>Colored</div> </div> <div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></div> <div>8. DATE OF BIRTH</div> <div>March 10, 1939</div> </div> <div> <div>9. AGE (In years last birthday)</div> <div>22 yrs.</div> </div> <div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Laborer</div> </div> <div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Laborer</div> </div> <div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>Virginia</div> </div> <div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div> </div> </div> <div> <div> <div>13. FATHER'S NAME</div> <div>James H. Collins</div> </div> <div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Olevia Upshur</div> </div> </div> <div> <div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)</div> <div>No</div> </div> <div> <div>16. SOCIAL SECURITY NO.</div> <div>230-50-4131</div> </div> <div> <div>17. INFORMANT</div> <div>James H. Collins, Williamsburg, Md.</div> </div> </div> <div> <div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Probable drowning</div> </div> <div> <div>929.8</div> <div>DUE TO</div> <div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>DUE TO</div> </div> </div> <div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> </div> </div> <div> <div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> </div> <div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>Found floating</div> </div> </div> <div> <div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>6:30 p.m. 8/7/ 1961</div> </div> <div> <div>20d. INJURY OCCURRED</div> <div>While <input type="checkbox"/> Not While <input checked="" type="checkbox"/></div> <div>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/></div> </div> <div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>Tomato juice pit Williamsburg, Dorchester, Md.</div> </div> <div> <div>20f. (City or town)</div> <div>Williamsburg, Dorchester, Md.</div> </div> </div> <div> <div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</div> <div>Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/></div> </div> <div> <div> <div>ACTUAL SIGNATURE</div> <div>Russell S. Fisher</div> </div> <div> <div>EXAMINER'S NAME (Type)</div> <div>Russell S. Fisher, M.D.</div> </div> </div> <div> <div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Rem-Burial</div> </div> <div> <div>22b. DATE THEREOF</div> <div>8/10/1961</div> </div> <div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>Painter Cemetery</div> </div> <div> <div>22d. LOCATION (City, town, or country)</div> <div>Painter, Virginia</div> </div> </div> <div> <div> <div>23. FUNERAL DIRECTOR</div> <div>Herbert M. St. Clair, Jr., Cambridge, Md.</div> </div> <div> <div>24a. REC'D BY REGISTRAR</div> <div>AUG 14 '61</div> </div> <div> <div>24b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. Kline</div> </div> </div> </div></div></div>											
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1994

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 22 & 23 Film G295 9/11/61 mh

9078

## CERTIFICATE OF DEATH

Items 22 Film G295 9/15/61 iwk

Reg. Dist. No. 09069

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>36Hrs. 3 Mins.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge, Md. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fredericka</b> Middle <b>Ann</b> Last <b>Collins</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>29</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28-1961</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frederick Collins</b>	
14. MOTHER'S MAIDEN NAME <b>Carol A. Rosetta</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mother-101 Academy St. Camb., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-28</b> , 19 <b>61</b> , to <b>8-29</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>8-29</b> , 19 <b>61</b> , and that death occurred at <b>12:40</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cambridge, Md.</b> DATE SIGNED <b>8-30-61</b>			
ACTUAL SIGNATURE <b>W. Baumann</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Wilbur N. Baumann 3 Church St. Cambridge, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/30/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Granville Le Compte</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 5 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH					
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF NOTARY		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF SURVIVOR		SIGNATURE OF HEIR		SIGNATURE OF ESTATE		SIGNATURE OF CREDITOR		SIGNATURE OF DEBTOR		SIGNATURE OF OTHER	

MADE IN

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE SIGNATURES ARE PROPERLY VERIFIED. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9079

## CERTIFICATE OF DEATH

Reg. Dist. No.

09070

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>				d. STREET ADDRESS <b>230 Pine Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lillian Foster Cornish</b>				4. DATE OF DEATH Month Day Year <b>Aug. 14, 1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 21, 1916</b>	9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canning</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Foster</b>				14. MOTHER'S MAIDEN NAME <b>Evelyn Stewart</b>			
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-01-9789</b>		17. INFORMANT Address <b>Evelyn Foster, Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Renal Disease</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>February 1, 1961</b> , to <b>August 14, 1961</b> , that I last saw the deceased alive on <b>August 14, 1961</b> , and that death occurred at <b>10 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>227 Pine St., Cambridge, Md. 8-17-61</b>							
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>							
PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/18/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Frawley</i>				24a. REC'D BY REGISTRAR DATE <b>AUG 22 61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frawley</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9080

CERTIFICATE OF DEATH

Reg. Dist. No. 09071

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fishing Creek, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fishing Creek, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>Creighton</b> Last <b>Creighton</b>				4. DATE OF DEATH Month <b>8</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/10/1879</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Fishing Creek, Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert F. Creighton</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Parker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Hansel Hall, Fishing Creek, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic CVD</b> (c) <b>yes.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-23</b> , 19 <b>56</b> , to <b>8-7</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>8-6</b> , 19 <b>61</b> , and that death occurred at <b>7 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3 Church Street</b> DATE SIGNED <b>W. N. Baumann</b>							
ACTUAL SIGNATURE <b>W. N. Baumann</b> M.D.				PHYSICIAN'S NAME (Type) <b>W. N. Baumann, M.D.</b> <b>Cambridge, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hoosier Memorial Church Yard</b>		22d. LOCATION (City, town, or county) (State) <b>Fishing Creek, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Md.</b>				24a. BY REGISTRAR <b>16 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9081

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09072

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b>				b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>60 years</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>306 Henry Street</b>				d. STREET ADDRESS <b>306 Henry Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph Ralph Dodson</b>				4. DATE OF DEATH Month Day Year <b>August 16, 1961</b>				5. SEX <b>Male</b>			
6. COLOR OR RACE <b>White</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>December 28, 1881</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman self employed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Somerset County</b>				9. AGE (In years last birthday) yrs. Months Days <b>79</b>			
13. FATHER'S NAME <b>James Dodson</b>				14. MOTHER'S MAIDEN NAME <b>Ida McClain</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Raymond J. Dodson, 306 Henry St., Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Starvation</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma stomach</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cambridge, Md.</b>		(County) <b>Dorchester</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>8/17/61</b> DATE SIGNED Address (Street, city, town, or county) <b>Cambridge, Md.</b>											
ACTUAL SIGNATURE <b>John Mace Jr.</b>				M.D. <b>John Mace Jr.</b>				DATE SIGNED <b>8/17/61</b>			
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				ADDRESS <b>Cambridge, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 21 '61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Aug. 18, 1961</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>			
22d. LOCATION (City, town, or country) <b>Cambridge, Md.</b>				22e. (State) <b>Dorchester</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			
23. FUNERAL DIRECTOR <b>Kenneth R. Thow</b>				ADDRESS <b>Cambridge, Md.</b>				24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

VS. A15ME  
5M 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09073

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Cambridge Md. Hospital</b>			d. STREET ADDRESS <b>23 Robbins St.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Grant</b>			4. DATE OF DEATH <b>Aug. 9 1961</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>Negro</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>3/12/1910</b>		
9. AGE (In years last birthday) <b>51 yrs.</b>			10. IF UNDER 1 YEAR Months Days		
11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Food Canning</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Grant Ennalls Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Amelia Travers</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>213-12-569</b>		
17. INFORMANT <b>Mrs. Christina E. Ennalls; Cambridge, Md</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8/10/61</b>					
Address (Street, city, town, or county) <b>Cambridge, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
22b. DATE THEREOF <b>8/13/61</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>Crapo Cemetery</b>					
22d. LOCATION (City, town, or country) (State) <b>Crapo, Dor. Md.</b>					
23. FUNERAL DIRECTOR <b>Herbert St. Clair</b> ADDRESS <b>Cambridge, Md.</b>					
24a. REC'D BY REGISTRAR <b>Aug 22 '61</b>					
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

MEDICAL CERTIFICATION

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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9083  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Dor</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elliott</u>		c. LENGTH OF STAY IN TB <u>all life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elliott</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Swain Robert Lee Ewell</u>				4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/27/1876</u>	9. AGE (In years, not birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Salomon Ewell</u>		14. MOTHER'S MAIDEN NAME <u>Mary W. Haller</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Emerson Moore Elliott</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr</u>		M.D. <u>JOHN MACE JR</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/27/61</u>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/28/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family</u>		22d. LOCATION (City, town, or county) (State) <u>Elliott Md</u>	
23. FUNERAL DIRECTOR <u>Ruth S. Halloway</u>		ADDRESS <u>East</u>		24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

MEDICAL CERTIFICATION

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9084

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G295 9/18/61 iwk

Reg. Dist. No.

09074

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillsboro</b>	
c. LENGTH OF STAY IN lb <b>3 days</b>		d. STREET ADDRESS <b>-</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>-</b> Last <b>Fleming</b>		4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-17-91</b>
9. AGE (in years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>17</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hackett Holt</b>		14. MOTHER'S MAIDEN NAME <b>Ella DuPont Turner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>RECORDS - Eastern Shore State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> DUE TO <b>465X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture neck left humerus 8/2/61</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped and fell in home</b>	
20c. TIME OF INJURY Month, Day, Year <b>9 AM 8/2/61 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Hillsboro, Caroline, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>8/21/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug 24, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillsboro Episcopal</b>	22d. LOCATION (City, town, or county) (State) <b>Hillsboro Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Virgil Keston + Son</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 24 '61</b>	
ADDRESS <b>Denton, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Keston</b>	

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: *John Doe*  
 SEX: *Male* AGE: *45*  
 RACE: *White* BIRTH DATE: *1900*  
 PLACE OF BIRTH: *Maryland*  
 OCCUPATION: *Teacher*  
 RESIDENCE: *123 Main St, Baltimore, Md.*  
 DATE OF DEATH: *1950* TIME OF DEATH: *10:00 AM*  
 PLACE OF DEATH: *Home*  
 CAUSE OF DEATH: *Myocardial Infarction*  
 MANNER OF DEATH: *Natural*  
 SIGNATURE OF EXAMINER: *John Doe*  
 TITLE: *Medical Examiner*  
 OFFICE: *Baltimore*

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: *John Doe*  
 SEX: *Male* AGE: *45*  
 RACE: *White* BIRTH DATE: *1900*  
 PLACE OF BIRTH: *Maryland*  
 OCCUPATION: *Teacher*  
 RESIDENCE: *123 Main St, Baltimore, Md.*  
 DATE OF DEATH: *1950* TIME OF DEATH: *10:00 AM*  
 PLACE OF DEATH: *Home*  
 CAUSE OF DEATH: *Myocardial Infarction*  
 MANNER OF DEATH: *Natural*  
 SIGNATURE OF EXAMINER: *John Doe*  
 TITLE: *Medical Examiner*  
 OFFICE: *Baltimore*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9085

09075

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A1SME  
5M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>East New Market, Md.</b> c. LENGTH OF STAY IN lb <b>5 Weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>None</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Lancaster</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lancaster, Pa.</b> d. STREET ADDRESS <b>618 S. Prince Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Webster</b>		4. DATE OF DEATH <b>8 15 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2 1886</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Shop</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Black &amp; Decker</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Friedel</b>		14. MOTHER'S MAIDEN NAME <b>Ella Wallheater</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Webster Friedel, 618 S. Prince St.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Instant</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Lancaster, Pa.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. DATE SIGNED <b>8/16/61</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/18/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn</b>	22d. LOCATION (City, town, or country) (State) <b>Lancaster, Pa.</b>
23. FUNERAL DIRECTOR <b>Le Compte Funeral Service, Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 18 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Mace</b>			

3222

(M)

(I)

Department of

Post Office, New York, N.Y.

Lancaster, Pa.

610 . . . . .

Register

Private

Male

White

May 2, 1938

Married

Black

John

Charles F. ...

John ...

No

No

Unknown

John ...

Commonly ...

*John ...*

John ...

File

1/10/1961

John ...

to George ...



1  
FOR STATE  
HEALTH DEPT  
M  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.  
VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9088 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09076											
1. PLACE OF DEATH e. COUNTY <u>Dor.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Airey</u> c. LENGTH OF STAY IN lb <u>all life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>—</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Dor.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Airey</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Linwood</u> Last <u>Harper</u>				4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>1961</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/27/83</u>		9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Harper</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Dunn</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Herbert L. Harper Jr. Airey Rd</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>8/16/61</u>			
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/18/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or country) (State) <u>East New Market, Md</u>					
23. FUNERAL DIRECTOR <u>Frank S. Hillyard</u> ADDRESS <u>East New Market, Md</u>				24a. REC'D BY REGISTRAR <u>AUG 22 1961</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Clara E. H. Hillyard</u>					



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

9087

09077

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>Williamsburg</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsburg</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Robert</b> Last <b>Medford</b>				4. DATE OF DEATH Month <b>August</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 15, 1879</b>		9. AGE (In years last birthday) yrs. <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert W. Medford</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Harper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Julia M. Medford, Williamsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BENIGN PROSTATIC HYPERTROPHY</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1/2 HR.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(was hospital)</del> attended the deceased from <b>10/10</b> 19 <b>59</b> to <b>8/29</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/29</b> 19 <b>61</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W. H. Hanks</b>				22b. DATE SIGNED <b>8/30/61</b>		22c. PHYSICIAN'S NAME (Type) <b>W. H. HANKS</b>	
22d. ADDRESS <b>CAMBRIDGE Md.</b>		22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 1, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Near Williamsburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Framptom and Son, Federalsburg, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 5 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony L. Hanks</b>	

bp

CERTIFICATE OF DEATH

2087

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9088 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 9079

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	c. LENGTH OF STAY IN lb <b>6 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Golt</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>14X-2</b>	
3. NAME OF DECEASED (Type or print) <b>Joseph W. Peacock</b> First Middle Last		4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/20/72</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-lumberman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Records E.S.S. Hospital- Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> 903.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture neck left femur</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 Min.</b> <b>22 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General arteriosclerosis</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped and fell to floor.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:30 AM 7-14-61</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	
20f. (City or town) <b>Cambridge</b>		(County) <b>Dor.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		DATE SIGNED <b>8/5/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/7/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Kenwood Cemetery</b>	22d. LOCATION (City, town, or county) <b>Sumner Bld.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Lister Smith Middletown</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 8 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Burial 8/5/11 Greenwood Cemetery  
Springer B.L.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9089

## CERTIFICATE OF DEATH

Reg. Dist. No.

09080

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>MARYLAND</u> <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RODGERS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>OSX-2</u>	
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>PEARSAUL</u> Last <u>PEARSAUL</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 24, 1871</u>
9. AGE (In years (on birthday) yrs.) <u>89</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MICHAEL H. SWING</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Myrtle Robertson</u>		Address <u>Clayton, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO <u>5 yrs</u> (c) <u>Intertrochanteric Fracture left hip</u> DUE TO <u>1 month</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/17/61</u> 19, to <u>8/17/61</u> 19, that I last saw the deceased alive on <u>8/17/61</u> 19, and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.		ADDRESS (Street, city or town, state) <u>136 Race St.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>		<u>Cambridge, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug 21, 1961</u>	<u>Denton</u>	<u>Denton, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jorge Hoover</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 24 '61</u>	
ADDRESS <u>Denton, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hunk</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

TO THE HONORABLE BOARD OF HEALTH, CITY OF BALTIMORE, MAY BE  
 MAY BE  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9090

## CERTIFICATE OF DEATH

Reg. Dist. No.

09081

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester, Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wingate, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wingate</b>			
c. LENGTH OF STAY IN 1b <b>Life</b>				d. STREET ADDRESS <b>None</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last <b>Lorena Jones Reynolds</b>		4. DATE OF DEATH Month Day Year <b>8 7 19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1884</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James E. Jones</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mr. Alfred Reynodls, Wingate, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cancerous Bladder</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-12</b> , 19 <b>61</b> to <b>8-7</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>8-5</b> , 19 <b>61</b> , and that death occurred at <b>4 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>W. N. Baumann</b> M.D.							
PHYSICIAN'S NAME (Type) <b>W. N. Baumann, M.D.</b>				<b>3 Church St., Cambridge, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/9/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Md.,</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 16 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED MARY ANN JONES		SEX FEMALE		AGE 65		DATE OF BIRTH JAN 15 1885		PLACE OF BIRTH BALTIMORE, MD.	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF DEATH DEC 10 1950		PLACE OF DEATH HOME	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF REGISTRAR W. B. JONES		SIGNATURE OF WITNESS M. A. JONES		SIGNATURE OF WITNESS J. H. SMITH		SIGNATURE OF WITNESS W. B. JONES	
NAME OF PHYSICIAN J. H. SMITH		NAME OF REGISTRAR W. B. JONES		NAME OF WITNESS M. A. JONES		NAME OF WITNESS J. H. SMITH		NAME OF WITNESS W. B. JONES	
ADDRESS OF DECEASED 1234 E. BALTIMORE AVE. BALTIMORE, MD.		ADDRESS OF PHYSICIAN 567 N. CALVERT ST. BALTIMORE, MD.		ADDRESS OF REGISTRAR 890 W. BALTIMORE ST. BALTIMORE, MD.		ADDRESS OF WITNESS 123 E. BALTIMORE AVE. BALTIMORE, MD.		ADDRESS OF WITNESS 567 N. CALVERT ST. BALTIMORE, MD.	

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9091 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03082

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salem</b>		c. LENGTH OF STAY IN 1b <b>Boonsboro Rt. #2</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro Rt. #2</b>		d. STREET ADDRESS <b>21X-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Hgwy. U.S.50</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Rosie Mae Shank</b>		4. DATE OF DEATH <b>August 7 1961</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>12/26/1898</b>		9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Boonsboro Md. Rt. #2</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>HARRY E. SMITH</b>		14. MOTHER'S MAIDEN NAME <b>ARNOLD Fannie Smith</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>1</b>	
17. INFORMANT <b>Mrs. Hazel Smith</b>		Address <b>Boonsboro Md. Rt. #2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial injury</b> DUE TO (b) <b>Multiple fractures skull</b> DUE TO (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Passenger in auto, in collision with another auto.</b>					
20c. TIME OF INJURY Month <b>8</b> Day <b>7</b> Year <b>1961</b> Hour <b>5</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 50 Near</b>		20f. (City or town) (County) (State) <b>Salem, Dor. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Dr. John Mace Jr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. John Mace Jr. M.D.</b>		DATE SIGNED <b>8/8/61</b>		Address (Street, city, town, or county) <b>Cambridge, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lena Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Boonsboro Md.</b>	
23. FUNERAL DIRECTOR <b>Kenneth R. Thomas Jr.</b>		24a. REC'D BY REGISTRAR <b>AUG 11 1961</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

MEDICAL CERTIFICATION

THE STATE  
OF NEW YORK



Thomas  
Gordon

Henry, W. S.

Robert

White

Honorable

Harry E.

No

Admission

W. S.

W. S.

W. S.

W. S.

W. S.

W. S.

W. S.

W. S.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9092 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09083											
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b> c. LENGTH OF STAY IN 1b <b>11 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Harrison Ferry Road</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b> d. STREET ADDRESS <b>Harrison Ferry Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Ross</b> Middle <b>Spears</b> Last <b>Spears</b>						4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22, 1904</b>		9. AGE (In years last birthday) <b>57 yrs.</b>		IF UNDER 1 YEAR Months <b>57</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Day Laborer at Pickle Plant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Pickle Plant</b>				11. BIRTHPLACE (State or foreign country) <b>Tennessee (Hawkins Co.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Spears</b>						14. MOTHER'S MAIDEN NAME <b>Eliza Waterson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Elizabeth Wheeler, Abingdon, Virginia</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Instant</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Aug. 9, 1961</b> Address (Street, city, town, or county)											
ACTUAL SIGNATURE <b>John Mace, Jr.</b> EXAMINER'S NAME (Type)				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>Aug. 13, 1961</b> 22c. NAME OF CEMETERY OR CREMATORY <b>High Point Cemetery</b> 22d. LOCATION (City, town, or country) (State) <b>Abingdon, Virginia</b>							
23. FUNERAL DIRECTOR <b>J. J. Framptom and Son, Federalsburg, Maryland</b> ADDRESS						24a. REC'D BY REGISTRAR <b>AUG 11 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knease</b>			

NAME  
SEX  
AGE

1

1

DATE  
TIME  
PLACE  
BY  
REMARKS

0000

*James M. [Signature]*

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9093 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 118084

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN TB <b>7yr 9mo 26days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Houston</b> Middle <b>Wesley</b> Last <b>Wheatley</b>		4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Wheatley</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Thompson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>RECORDS: Eastern Shore State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture neck r. femur</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Se nile brain disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped and fell on ward of hospital.</b>	
20c. TIME OF INJURY Month, Day, Year <b>7.25 AM 6-30-61 19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) (County) (State) <b>Cambridge Dor. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED <b>8/24/61</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-26-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>EAST NEW MARKET</b>	22d. LOCATION (City, town, or county) (State) <b>EAST NEW MARKET, MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>SMITH FUNERAL HOME, SHARPTOWN, MD</b>		24a. REC'D BY REGISTRAR <b>AUG 29 '61</b> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
DEATH CERT.

(M)

(1)

MARYLAND STATEMENT OF HEALTH & MANNER OF DEATH  
2022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED'S NAME: [REDACTED]  
2. SEX: [REDACTED] AGE: [REDACTED]  
3. DATE OF BIRTH: [REDACTED]  
4. PLACE OF BIRTH: [REDACTED]  
5. RACE: [REDACTED]  
6. ETHNICITY: [REDACTED]  
7. OCCUPATION: [REDACTED]  
8. PRESENT ADDRESS: [REDACTED]  
9. PERMANENT ADDRESS: [REDACTED]  
10. SOCIAL SECURITY NUMBER: [REDACTED]  
11. MARITAL STATUS: [REDACTED]  
12. DATE OF DEATH: [REDACTED]  
13. TIME OF DEATH: [REDACTED]  
14. PLACE OF DEATH: [REDACTED]  
15. CAUSE OF DEATH: [REDACTED]  
16. MANNER OF DEATH: [REDACTED]  
17. SIGNATURE OF MEDICAL EXAMINER: [REDACTED]  
18. DATE OF SIGNATURE: [REDACTED]  
19. SIGNATURE OF WITNESS: [REDACTED]  
20. DATE OF SIGNATURE: [REDACTED]

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9094 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09085											
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-Vienna</b> c. LENGTH OF STAY IN 1b <b>Few Mos.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-Vienna</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Jonnie L. Wilson</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>5</b> Year <b>19 61</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 5, 1915</b>		9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>5</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>				11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Annie Carpenter</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>W.W. II 425-34-2713</b>		17. INFORMANT Address <b>Annie C. Wilson, Winona, Miss.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>981X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gunshot wounds abdomen</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b> <b>Few mins.</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was shot 5 times by another man.</b>							
20c. TIME OF INJURY Month, Day, Year <b>12:10 a.m. 8/5/61 19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Dorco Labor Camp Nr. Vienna, Dor. Md.</b>		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John Mace Jr.</b>				M.D. <b>Dr. John Mace Jr. M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/10/61</b>	
EXAMINER'S NAME (Type) <b>Dr. John Mace Jr. M.D.</b>				Address (Street, city, town, or county) <b>Cambridge, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8/10/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Winona Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Winona, Mississippi</b>			
23. FUNERAL DIRECTOR <b>Herbert H. H. H. H.</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 14 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linkwood</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Linkwood</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>VAN</u> First <u>Byren</u> Middle <u>Wright</u> Last		4. DATE OF DEATH <u>Aug</u> Month <u>3</u> Day <u>1961</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1885</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wright</u>		14. MOTHER'S MAIDEN NAME <u>Frances Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>—</u>	
17. INFORMANT <u>Mrs. Alberta Wright - Linkwood, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 20</u> 19 <u>61</u> , to <u>Aug 3</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 2</u> 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Edwin Fasset</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Fasset</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-7-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EIZEY'S Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Jesterville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Shell</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 9 '61</u>	
ADDRESS <u>EASTON, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kears</u>	

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